STATEMENT OF EMERGENCY
907 KAR 15:020E

This emergency administrative regulation is being promulgated to implement state and federal changes to services provided by behavioral health services organizations. This emergency administrative regulation is needed pursuant to KRS 13A.190(1)(a)1. to meet an imminent threat to public health and pursuant to KRS 13A.190(1)(a)2. to prevent a loss of federal funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation. The ordinary administrative regulation is not identical to this emergency administrative regulation as this emergency administrative regulation includes an additional Section 13 to establish an implementation date of July 1, 2019.

MATTHEW G. BEVIN, Governor
ADAM M. MEIER, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Emergency Amendment)

907 KAR 15:020E. Coverage provisions and requirements regarding services provided by behavioral health services organizations for mental health treatment.


STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

EFFECTIVE: June 28, 2019

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by tier I behavioral health services organizations.

Section 1. General Coverage Requirements. (1) For the department to reimburse for a service covered under this administrative regulation, the service shall be:
(a) Medically necessary; and
(b) Provided:
1. To a recipient; and
2. By a behavioral health services organization that meets the provider participation requirements established in Section 2 of this administrative regulation.
(2)(a) Direct contact between a practitioner and a recipient shall be required for each service except for:
1. Collateral outpatient therapy for a child under the age of twenty-one (21) years if the collateral outpatient therapy is in the child’s plan of care;
2. A family outpatient service in which the corresponding current procedural terminology code establishes that the recipient is not present; or

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3. A psychological testing service comprised of interpreting or explaining results of an examination or data to family members or other kin if the corresponding current procedural terminology code establishes that the recipient is not present.
   (b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(3) A billable unit of service shall be actual time spent delivering a service in an [a face-to-face] encounter.

(4) A service shall be:
   (a) Stated in the recipient's plan of care; and
   (b) Provided in accordance with the recipient's plan of care.

(5)(a) A behavioral health services organization shall establish a plan of care for each recipient receiving services from the behavioral health services organization.
   (b) A plan of care shall meet the plan of care requirements established in 902 KAR 20:430.

Section 2. Provider Participation. (1) To be eligible to provide services under this administrative regulation, a behavioral health services organization shall:
   (a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;
   (b) Be currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and
   (c) Have:
      1. For each service it provides, the capacity to provide the full range of the service as established in this administrative regulation;
      2. Documented [Demonstrated] experience in serving individuals with behavioral health disorders;
      3. The administrative capacity to ensure quality of services;
      4. A financial management system that provides documentation of services and costs; and
      5. The capacity to document and maintain individual case records.

   (2) In accordance with 907 KAR 17:015, Section 3(3), a behavioral health services organization which provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

   (3) A BHSO I shall:
      (a) Not receive reimbursement for services provided for outpatient or residential substance use disorder treatment;
      (b) Provide services in accordance with its licensure, 902 KAR 20:430, and Section 3 of this administrative regulation for mental health treatment; and
      (c) Possess accreditation within one (1) year of initial enrollment by one (1) of the following:
         1. The Joint Commission;
         2. The Commission on Accreditation of Rehabilitation Facilities;
         3. The Council on Accreditation; or
         4. A nationally recognized accreditation organization.
Section 3. Covered Services. (1) The following providers shall not be eligible to provide services under this administrative regulation for a BHSO I:

(a) A licensed clinical alcohol and drug counselor (LCADC);
(b) A licensed clinical alcohol and drug counselor associate (LCADCA);
(c) A certified alcohol and drug counselor (CADC); or
(d) A substance use disorder peer support specialist.

(2) A physician providing behavioral health services in a BHSO I shall possess a psychiatric specialty.

(3) An advanced practice registered nurse providing behavioral health services in a BHSO I shall possess a psychiatric specialty.

(4) A physician assistant providing behavioral health services in a BHSO I shall have a contractual relationship with a supervising physician who has a psychiatric specialty.

(5) Except as specified in the requirements stated for a given service, the services covered may be provided for a mental health disorder; Substance use disorder; or Co-occurring mental health and substance use disorders.

(6) The following services established in this subsection shall be covered under this administrative regulation in accordance with the corresponding requirements established in this section:

(a) A screening, crisis intervention, or intensive outpatient program service provided by:
1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A licensed clinical social worker;
4. A licensed professional clinical counselor;
5. A licensed professional art therapist;
6. A licensed marriage and family therapist;
7. A physician;
8. A psychiatrist;
9. An advanced practice registered nurse; or
10. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;

(b) An assessment provided by:
1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A licensed clinical social worker;
4. A licensed professional clinical counselor;
5. A licensed professional art therapist;
6. A licensed marriage and family therapist;
7. A physician;
8. A psychiatrist;
9. An advanced practice registered nurse; or
10. A licensed behavior analyst; or
11. A behavioral health practitioner under supervision;

(c) Psychological testing provided by:
1. A licensed psychologist;
2. A licensed psychological associate working under the supervision of a licensed psychologist; or
3. A licensed psychological practitioner;
(d) Day treatment, mobile crisis services, or residential services for substance use disorders provided by:
1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A licensed clinical social worker;
4. A licensed professional clinical counselor;
5. A licensed professional art therapist;
6. A licensed marriage and family therapist;
7. A physician;
8. A psychiatrist;
9. An advanced practice registered nurse;
10. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst; or
11. A peer support specialist working under the supervision of:
a. An approved behavioral health services provider; or
b. A certified alcohol and drug counselor;
(e) Peer support provided by a peer support specialist working under the supervision of:
1. An approved behavioral health services provider; or
2. A certified alcohol and drug counselor;
(f) Individual outpatient therapy, group outpatient therapy, or collateral outpatient therapy provided by:
1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A licensed clinical social worker;
4. A licensed professional clinical counselor;
5. A licensed professional art therapist;
6. A licensed marriage and family therapist;
7. A physician;
8. A psychiatrist;
9. An advanced practice registered nurse;
10. A licensed behavior analyst; or
11. A behavioral health practitioner under supervision;
(g) Family outpatient therapy provided by:
1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A licensed clinical social worker;
4. A licensed professional clinical counselor;
5. A licensed professional art therapist;
6. A licensed marriage and family therapist;
7. A physician;
8. A psychiatrist;
9. An advanced practice registered nurse; or
10. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;
(h) Service planning provided by:
1. A licensed psychologist;
2. A licensed psychological practitioner;
3. A licensed clinical social worker;
4. A licensed professional clinical counselor;
5. A licensed professional art therapist;
6. A licensed marriage and family therapist;
7. A physician;
8. A psychiatrist;
9. An advanced practice registered nurse;
10. A licensed behavior analyst; or
11. A behavioral health practitioner under supervision except for a certified alcohol and drug counselor;
   (i) A screening, brief intervention, and referral to treatment for a substance use disorder or SBIRT provided by:
   1. A licensed psychologist;
   2. A licensed psychological practitioner;
   3. A licensed clinical social worker;
   4. A licensed professional clinical counselor;
   5. A licensed professional art therapist;
   6. A licensed marriage and family therapist;
   7. A physician;
   8. A psychiatrist;
   9. An advanced practice registered nurse; or
   10. A behavioral health practitioner under supervision except for a licensed assistant behavior analyst;
   (j) Assertive community treatment provided by:
   1. A licensed psychologist;
   2. A licensed psychological practitioner;
   3. A licensed clinical social worker;
   4. A licensed professional clinical counselor;
   5. A licensed professional art therapist;
   6. A licensed marriage and family therapist;
   7. A physician;
   8. A psychiatrist;
   9. An advanced practice registered nurse;
   10. A behavioral health practitioner under supervision except for a:
       a. Licensed assistant behavior analyst; or
       b. Certified alcohol and drug counselor;
   11. A peer support specialist working under the supervision of an approved behavioral health services provider; or
   12. A community support associate;
   (k) Comprehensive community support services provided by:
   1. A licensed psychologist;
   2. A licensed psychological practitioner;
   3. A licensed clinical social worker;
   4. A licensed professional clinical counselor;
   5. A licensed professional art therapist;
   6. A licensed marriage and family therapist;
   7. A physician;
   8. A psychiatrist;
   9. An advanced practice registered nurse;
   10. A licensed behavior analyst;
11. A behavior health practitioner under supervision except for a certified alcohol and drug counselor; or
12. A community support associate; or
(l) Therapeutic rehabilitation program services provided by:
   1. A licensed psychologist;
   2. A licensed psychological practitioner;
   3. A licensed clinical social worker;
   4. A licensed professional clinical counselor;
   5. A licensed professional art therapist;
   6. A licensed marriage and family therapist;
   7. A physician;
   8. A psychiatrist;
   9. An advanced practice registered nurse;
10. A behavioral health practitioner under supervision except for a:
   a. Licensed assistant behavior analyst; or
   b. Certified alcohol and drug counselor; or
11. A peer support specialist working under the supervision of an approved behavioral health services provider.

(3)(a) A screening shall:
   1. Determine the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorders;
   2. Not establish the presence or specific type of disorder; and
   3. Establish the need for an in-depth assessment;
   4. Be face-to-face or via telehealth, as appropriate pursuant to 907 KAR 3:170; and
   5. Be provided by:
      a. An approved behavioral health practitioner; or
      b. An approved behavioral health practitioner under supervision.
(b) An assessment shall:
   1. Include gathering information and engaging in a process with the individual that enables the practitioner to:
      a. Establish the presence or absence of a mental health disorder, substance use disorder, or co-occurring disorders;
      b. Determine the individual’s readiness for change;
      c. Identify the individual’s strengths or problem areas that may affect the treatment and recovery processes; and
      d. Engage the individual in developing an appropriate treatment relationship;
   2. Establish or rule out the existence of a clinical disorder or service need;
   3. Include working with the individual to develop a plan of care; and
   4. Not include psychological or psychiatric evaluations or assessments;
   5. Be face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170; and
   6. Be provided by:
      a. An approved behavioral health practitioner; or
      b. An approved behavioral health practitioner under supervision.
(c)(1) Psychological testing shall include:
   a.[1.] A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and
   b.[2.] Interpretation and a written report of testing results.
   2. Psychological testing shall be provided face-to-face or via telehealth as appropriate pursuant to 907 KAR 3:170.
3. Psychological testing shall be provided by:
   a. A licensed psychologist;
   b. A certified psychologist with autonomous functioning;
   c. A licensed psychological practitioner;
   d. A certified psychologist under supervision; or
   e. A licensed psychological associate under supervision.

(d) Crisis intervention:
   1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating
      the risk of physical or emotional harm to:
      a. The recipient; or
      b. Another individual;
   2. Shall consist of clinical intervention and support services necessary to provide integrated
      crisis response, crisis stabilization interventions, or crisis prevention activities for individuals;
   3. Shall be provided:
      a. On-site at the behavioral health services organization’s office;
      b. As an immediate relief to the presenting problem or threat; and
      c. In a face-to-face, one (1) on one (1) encounter between the provider and the recipient or
         as a comparable service provided via telehealth as appropriate pursuant to 907 KAR 3:170;
   4. Shall be followed by a referral to non-crisis services if applicable;[and]
   5. May include:
      a. Further service prevention planning including:
         (i) lethal means reduction for suicide risk; or
         (ii) Substance use disorder relapse prevention; or
      b. Verbal de-escalation, risk assessment, or cognitive therapy; and
   6. Shall be provided by:
      a. An approved behavioral health practitioner; or
      b. An approved behavioral health practitioner under supervision.

(e) Mobile crisis services shall:
   1. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the year;
   2. Be provided for a duration of less than twenty-four (24) hours;
   3. Not be an overnight service;
   4. Be provided via face-to-face contact or telehealth, as appropriate pursuant to 907 KAR
      3:170, by a multi-disciplinary team based intervention in a home or community setting that
      ensures access to mental health and substance use disorder services and supports to:
      a. Reduce symptoms or harm; or
      b. Safely transition an individual in an acute crisis to the appropriate least restrictive level
         of care;
   5. Involve all services and supports necessary to provide:
      a. Integrated crisis prevention;
      b. Assessment and disposition;
      c. Intervention;
      d. Continuity of care recommendations; and
      e. Follow-up services;[and]
   6. Be provided face-to-face in a home or community setting;
   7. Include access to a board-certified or board-eligible psychiatrist twenty-four (24) hours a
day, seven (7) days a week, every day of the year; and
   8. Be provided by:
      a. An approved behavioral health practitioner;
      b. An approved behavioral health practitioner under supervision; or
c. A peer support specialist who:
   (i) Is under the supervision of an approved behavioral health practitioner; and
   (ii) Provides support services under this paragraph.

(f)1. Day treatment shall be a non-residential, intensive treatment program for a child under
the age of twenty-one (21) years who has:
   a. A mental health disorder, substance use disorder, or co-occurring mental health and
   substance use disorders; and
   b. A high risk of out-of-home placement due to a behavioral health issue.

2. Day treatment shall:
   a. Consist of an organized, behavioral health program of treatment and rehabilitative ser-
   vices;
   b. Include:
      (i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;
      (ii) Behavior management and social skills training;
      (iii) Independent living skills that correlate to the age and developmental stage of the recipi-
      ent; or
      (iv) Services designed to explore and link with community resources before discharge and
   to assist the recipient and family with transition to community services after discharge; and
   c. Be provided:
      (i) In collaboration with the education services of the local education authority including
      those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or
      29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);
      (ii) On school days and during scheduled school breaks;
      (iii) In coordination with the recipient’s individualized education program or Section 504 plan if the recipient has an individualized education program or Section 504 plan;
      (iv) Under the supervision of an approved behavioral health practitioner or an approved behavioral health practitioner working under clinical supervision; and
      (v) With a linkage agreement with the local education authority that specifies the responsibil-
      ies of the local education authority and the day treatment provider; and
      (vi) Face-to-face.

3. To provide day treatment services, a behavioral health services organization shall have:
   a. The capacity to employ staff authorized to provide day treatment services in accordance
   with this section and to coordinate the provision of services among team members; and
   b. Knowledge of mental health disorders.

4. Day treatment shall not include a therapeutic clinical service that is included in a child’s
individualized education program or Section 504 plan.

5. a. Day treatment shall be provided by:
   (i) An approved behavioral health practitioner; or
   (ii) An approved behavioral health practitioner under supervision.

   b. A peer support specialist working under the supervision of an approved behavioral health
   practitioner may provide support services under this paragraph.

( g )1. Peer support services shall:
   a. Be emotional support that is provided by:
      (i) An individual who has been trained and certified in accordance with 908 KAR 2:220 and
      who is experiencing or has experienced a mental health disorder, substance use disorder, or
      co-occurring mental health and substance use disorders] to a recipient by sharing a similar
      mental health disorder, substance use disorder, or co-occurring mental health and substance
use disorders] in order to bring about a desired social or personal change;
(ii) A parent or other family member, who has been trained and certified in accordance with 908 KAR 2:230, of a child having or who has had a mental health disorder[,... substance use, or co-occurring mental health and substance use disorders] to a parent or family member of a child sharing a similar mental health disorder[,... substance use, or co-occurring mental health and substance use disorders] in order to bring about a desired social or personal change; or
(iii) An individual[A family member], who has been trained and certified in accordance with 908 KAR 2:240 and identified as experiencing as a child or youth an emotional, social, or behavioral disorder that is defined in the current version of the Diagnostic and Statistical Manual for Mental Disorders[2:230, of a child having or who has had a mental health, substance use, or co-occurring mental health and substance use disorders to a parent or family member of a child sharing a similar mental health, substance use, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change];

b. Be an evidence-based practice;

(c) Be structured and scheduled non-clinical therapeutic activities with an individual recipient or a group of recipients;

d. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient;

e. Be coordinated within the context of a comprehensive, individualized plan of care developed through a person-centered planning process;

(f) Be identified in each recipient’s plan of care and

g. Be designed to directly contribute to the recipient’s individualized goals as specified in the recipient’s plan of care; and

(h). Be provided face-to-face.

2. To provide peer support services, a behavioral health services organization shall:

a. Have demonstrated:

(i) The capacity to provide peer support services for the behavioral health population being served including the age range of the population being served; and

(ii) Experience in serving individuals with behavioral health disorders;

b. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220, 908 KAR 2:230, or 908 KAR 2:240;

c. Use an approved behavioral health practitioner[service provider or certified alcohol and drug counselor] to supervise peer support specialists;

(d) Have the capacity to coordinate the provision of services among team members; and

e. Have the capacity to provide on-going continuing education and technical assistance to peer support specialists;

f. Require individuals providing peer support services to recipients to provide no more than 120 units per week of direct recipient contact; and

g. Require peer support services provided to recipients in a group setting not exceed eight (8) individuals within any group at a time.

(h)1. Intensive outpatient program services shall:

(a) Be an alternative to or transition from a higher level of care[inpatient hospitalization or partial hospitalization] for a mental health disorder[,... substance use disorder, or co-occurring disorders];

(b) Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy;

(c) Be provided at least three (3) hours per day at least three (3) days per week for adults; and
d. Be provided at least six (6) hours per week for adolescents;
e. Include:
   (i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless contraindicated;
   (ii) Crisis intervention; or
   (iii) Psycho-education related to identified goals in the recipient’s treatment plan; and
f. Be provided face-to-face.

2. During psycho-education, the recipient or recipient’s family member shall be:
a. Provided with knowledge regarding the recipient’s diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and
b. Taught how to cope with the recipient’s diagnosis or condition in a successful manner.

3. An intensive outpatient program services treatment plan shall:
a. Be individualized; and
b. Focus on stabilization and transition to a lesser level of care.

4. To provide intensive outpatient program services, a behavioral health services organization shall have:
a. Access to a board-certified or board-eligible psychiatrist for consultation;
b. Access to a psychiatrist, physician, or advanced practiced registered nurse for medication prescribing and monitoring;
c. Adequate staffing to ensure a minimum recipient-to-staff ratio of ten (10) recipients to one (1) staff person;
d. The capacity to provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles; and
e. The capacity to employ staff authorized to provide intensive outpatient program services in accordance with this section and to coordinate the provision of services among team members.

5. Intensive outpatient program services shall be provided by:
a. An approved behavioral health practitioner, except for a licensed behavior analyst; or
b. An approved behavior health practitioner under supervision, except for a licensed assistant behavior analyst.

(i) Individual outpatient therapy shall:
1. Be provided to promote the:
   a. Health and wellbeing of the individual; and
   b. Restoration of a recipient to the recipient’s best possible functional level [Recovery] from a substance use disorder, mental health disorder, or co-occurring mental health and substance use disorders;
2. Consist of:
   a. A face-to-face, one (1) on one (1) encounter between the provider and recipient or provided via telehealth as appropriate pursuant to 907 KAR 3:170; and
   b. A behavioral health therapeutic intervention provided in accordance with the recipient’s identified plan of care;
3. Be aimed at:
   a. Reducing adverse symptoms;
   b. Reducing or eliminating the presenting problem of the recipient; and
   c. Improving functioning; [and]
4. Not exceed three (3) hours per day, alone or in combination with any other outpatient therapy per recipient, unless additional time is medically necessary; and
5. Be provided by:
   a. An approved behavioral health practitioner; or
b. An approved behavioral health practitioner under supervision.

(j) 1. Group outpatient therapy shall:
   a. Be a behavioral health therapeutic intervention provided in accordance with a recipient’s identified plan of care;
   b. Be provided to promote the:
      (i) Health and wellbeing of the individual; and
      (ii) Restoration of a recipient to the recipient’s best possible functional level[Recovery] from a substance use disorder, mental health disorder[, or co-occurring mental health and substance use disorders];
   c. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient’s identified plan of care;
   d. Be provided to a recipient in a group setting:
      (i) Of nonrelated individuals except for multi-family group therapy; and
      (ii) Not to exceed twelve (12) individuals in size;
   e. Focus on the psychological needs of the recipients as evidenced in each recipient’s plan of care;
   f. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;
   g. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and
   h. Not exceed three (3) hours per day, alone or in combination with any other outpatient therapy, per recipient unless additional time is medically necessary.

2. The group shall have a:
   a. Deliberate focus; and
   b. Defined course of treatment.

3. The subject of group outpatient therapy shall relate to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient’s health record.

5. Group outpatient therapy shall be provided by:
   a. An approved behavioral health practitioner; or
   b. An approved behavioral health practitioner under supervision.

(k) 1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention or occur via telehealth as appropriate pursuant to 907 KAR 3:170, provided:
   a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient’s family; and
   b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient’s home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

3. Family outpatient therapy shall:
   a. Be provided to promote the:
      (i) Health and wellbeing of the individual; or
      (ii) Restoration of a recipient to the recipient’s best possible functional level[Recovery] from a substance use disorder, mental health disorder[, or co-occurring mental health and substance use disorders]; and
   b. Not exceed three (3) hours per day alone or in combination with any other outpatient therapy per recipient[individual] unless additional time is medically necessary.
4. Family outpatient therapy shall be provided by:
a. An approved behavioral health practitioner; or
b. An approved behavioral health practitioner under supervision.
(i) Collateral outpatient therapy shall:
   a. Consist of a face-to-face behavioral health consultation or occur via telehealth as appropriate pursuant to 907 KAR 3:170:
      (i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and
      (ii) That is provided in accordance with the recipient’s plan of care; and
b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age; and
c. Not exceed three (3) hours per day per individual unless additional time is medically necessary.
2. Written consent by a parent or custodial guardian to discuss a recipient’s treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient’s health record.
3. Collateral outpatient therapy shall be provided by:
   a. An approved behavioral health practitioner; or
   b. An approved behavioral health practitioner under supervision.
(m) Service planning shall:
   a. Involve assisting a recipient in creating an individualized plan for services and developing measurable goals and objectives needed for maximum reduction of the effects of a mental health disorder;
   b. Involve restoring a recipient's functional level to the recipient's best possible functional level; and
   c. Be performed using a person-centered planning process; and
   d. Be provided face-to-face.
2. A service plan:
   a. Shall be directed and signed by the recipient;
   b. Shall include practitioners of the recipient’s choosing; and
   c. May include:
      (i) A mental health advance directive being filed with a local hospital;
      (ii) A crisis plan; or
      (iii) A relapse prevention strategy or plan.
3. Service planning shall be provided by:
   a. An approved behavioral health practitioner; or
   b. An approved behavioral health practitioner under supervision.
(n) Residential services for substance use disorders shall:
   a. Be provided in a twenty-four (24) hour per day unit that is a live-in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring mental health and substance use disorders;
   b. Be short or long-term to provide intensive treatment and skills building in a structured and supportive environment;
   c. Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;
   d. Assist a recipient in making necessary changes in the recipient’s life to enable the recipient to live drug- or alcohol-free;
   e. Be provided under the medical direction of a physician;
f. Provide continuous nursing services in which a registered nurse shall be:
   (i) On-site during traditional first shift hours, Monday through Friday;
   (ii) Continuously available by phone after hours; and
   (iii) On-site as needed in follow-up to telephone consultation after hours;

g. Be based on individual need and may include:
   (i) A screening;
   (ii) An assessment;
   (iii) Service planning;
   (iv) Individual outpatient therapy;
   (v) Group outpatient therapy;
   (vi) Family outpatient therapy; or
   (vii) Peer support; and

h. Be provided in accordance with 908 KAR 1:370.

2. a. Except as established in clause b of this subparagraph, the physical structure in which
   residential services for substance use disorders is provided shall:
      (i) Have between nine (9) and sixteen (16) beds; and
      (ii) Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds
           in aggregate.

b. If every recipient receiving services in the physical structure is under the age of twenty-one (21) years or over the age of sixty-five (65) years, the limit of sixteen (16) beds established
   in clause a of this subparagraph shall not apply.

3. A short-term length-of-stay for residential services for substance use disorders:
   a. Shall be less than thirty (30) days in duration;
   b. Shall include planned clinical program activities constituting at least fifteen (15) hours per
      week of structured professionally-directed treatment activities to:
         (i) Stabilize a recipient's substance use disorder; and
         (ii) Help the recipient develop and apply recovery skills; and
         (iii) May include the services listed in subparagraph 1.g. of this paragraph.

4. A long-term length-of-stay for residential services for substance use disorders:
   a. Shall be between thirty (30) days and ninety (90) days in duration;
   b. Shall include planned clinical program activities constituting at least forty (40) hours per
      week of structured professionally-directed treatment activities to:
         (i) Stabilize a recipient's substance use disorder; and
         (ii) Help the recipient develop and apply recovery skills; and
         (iii) May include the services listed in subparagraph 1.g. of this paragraph.

5. Residential services for substance use disorders shall not include:
   a. Room and board;
   b. Educational services;
   c. Vocational services;
   d. Job training services;
   e. Habilitation services;
   f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;
   g. Services to an individual residing in an institution for mental diseases pursuant to 42
      C.F.R. 435.1010;
   h. Recreational activities;
   i. Social activities; or
   j. Services required to be covered elsewhere in the Medicaid state plan.

6. To provide residential services for substance use disorders, a behavioral health services
   organization shall:
a. Have the capacity to employ staff authorized to provide services in accordance with this section and to coordinate the provision of services among team members; and

b. Be licensed as a non-medical and non-hospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370.

(o) Screening, brief intervention, and referral to treatment for a substance use disorder shall:
1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and

2. Consist of:
   a. Using a standardized screening tool to assess an individual for risky substance use behavior;
   b. Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and
   c. Referring a recipient to additional mental health disorder, substance use disorder, or co-occurring disorders services if the recipient is determined to need additional services to address substance use.

(pp)1. Assertive community treatment shall:
   a. Be an evidence-based psychiatric rehabilitation practice that provides a comprehensive approach to service delivery for individuals with a serious mental illness; and

   b. Include:
      (i) Assessment;
      (ii) Treatment planning;
      (iii) Case management;
      (iv) Psychiatric services;
      (v) Medication prescribing and monitoring;
      (vi) Individual outpatient therapy;
      (vii) Family outpatient therapy;
      (viii) Group outpatient therapy;
      (ix) Mobile crisis services;
      (x) Crisis intervention;
      (xi) Mental health consultation; or
      (xii) Family support and basic living skills; and

   c. Be provided face-to-face.

2.a. Mental health consultation shall involve brief, collateral interactions with other treating professionals who may have information for the purpose of treatment planning and service delivery.

b. Family support shall involve the assertive community treatment team’s working with the recipient’s natural support systems to improve family relations in order to:
   (i) Reduce conflict; and
   (ii) Increase the recipient’s autonomy and independent functioning.

c. Basic living skills shall be rehabilitative services focused on teaching activities of daily living necessary to maintain independent functioning and community living.

3. To provide assertive community treatment services, a behavioral health services organization shall:
   a. Employ at least one (1) team of multidisciplinary professionals:
      (i) Led by an approved behavioral health services practitioner[provider]; and
      (ii) Comprised of at least four (4) full-time equivalents including a prescriber, a nurse, an approved behavioral health services practitioner[provider], or a case manager[. or a co-occurring disorder specialist];
b. Have adequate staffing to ensure that a team’s caseload size shall not exceed ten (10) participants per team member (for example, if the team includes five (5) individuals, the caseload for the team shall not exceed fifty (50) recipients);

c. Have the capacity to:

(i) Employ staff authorized to provide assertive community treatment services in accordance with this paragraph;

(ii) Coordinate the provision of services among team members;

(iii) Provide the full range of assertive community treatment services as stated in this paragraph; and

(iv) Document and maintain individual case records; and

d. Demonstrate experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community.

4. Assertive community treatment shall be provided by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

5. a. A peer support specialist under the supervision of an approved behavioral health practitioner may provide support services under this paragraph.

b. A community support associate under supervision of an approved behavioral health practitioner may provide support services under this paragraph.

(o)(q)1. Comprehensive community support services shall:

a. Be activities necessary to allow an individual to live with maximum independence in the community;

b. Be intended to ensure successful community living through the utilization of skills training as identified in the recipient’s plan of care;

and

c. Consist of using a variety of psychiatric rehabilitation techniques to:

(i) Improve daily living skills;

(ii) Improve self-monitoring of symptoms and side effects;

(iii) Improve emotional regulation skills;

(iv) Improve crisis coping skills; and

(v) Develop and enhance interpersonal skills; and

b. Be provided face-to-face.

2. To provide comprehensive community support services, a behavioral health services organization shall:

a. Have the capacity to employ staff authorized pursuant to 908 KAR 2:250 to provide comprehensive community support services in accordance with subsection (2)(k) of this section and to coordinate the provision of services among team members; and

b. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

3. Comprehensive community support services shall be provided by:

a. An approved behavioral health practitioner; or

b. An approved behavioral health practitioner under supervision.

4. a. A community support associate under supervision of an approved behavioral health practitioner may provide support services under this paragraph.

b. A registered behavioral technician under the supervision of a licensed behavior analyst may provide support services under this paragraph.

(p)(#)1. Therapeutic rehabilitation program services shall be:

a. A rehabilitative service for an:

(i) Adult with a serious mental illness; or

(ii) Individual under the age of twenty-one (21) years who has a serious emotional disability;
b. Designed to maximize the reduction of the effects of a mental health disorder and the restoration of the individual's functional level to the individual's best possible functional level; and

c. Provided face-to-face.

2. A recipient in a therapeutic rehabilitation program shall establish the recipient’s own rehabilitation goals within the person-centered service plan.

3. A therapeutic rehabilitation program shall:
   a. Provide face-to-face, on-site psychiatric rehabilitation and supports;
   b. Be delivered using a variety of psychiatric rehabilitation techniques;
   c. Focus on:
      i. Improving daily living skills;
      ii. Self-monitoring of symptoms and side effects;
      iii. Emotional regulation skills;
      iv. Crisis coping skill; and
      v. Interpersonal skills;
   d. Be delivered individually or in a group; and
   e. Include:
      i. An individualized plan of care identifying measurable goals and objectives including discharge and relapse prevention planning;
      ii. Coordination of services the individual may be receiving; and
      iii. Referral to other necessary service supports as needed.

4. Therapeutic rehabilitation staffing shall include:
   a. Licensed clinical supervision, consultation, and support to direct care staff; and
   b. Direct care staff to provide scheduled therapeutic activities, training, and support for Medicaid recipients.

5. Therapeutic rehabilitation program services shall be provided by:
   a. An approved behavioral health practitioner, except for a licensed behavior analyst; or
   b. An approved behavioral health practitioner under supervision, except for a licensed assistant behavior analyst.

6. A peer support specialist working under the supervision of an approved behavioral health practitioner may provide support services under this paragraph.

q1. Partial hospitalization services shall be:
   a. Short-term with an average of four (4) to six (6) weeks;
   b. Less than twenty-four (24)-hours each day; and
   c. An intensive treatment program for an individual who is experiencing significant impairment to daily functioning due to a mental health disorder.

2. Partial hospitalization may be provided to an adult or a minor.

3. Admission criteria for partial hospitalization shall be based on an inability of community-based therapies or intensive outpatient services to adequately treat the recipient.

4. A partial hospitalization program shall consist of:
   a. Individual outpatient therapy;
   b. Group outpatient therapy;
   c. Family outpatient therapy; or
   d. Medication management.

5. The department shall not reimburse for educational, vocational, or job training services provided as part of partial hospitalization.

6. An outpatient behavioral health services organization's partial hospitalization program shall have an agreement with the local educational authority to come into the program to provide all educational components and instruction that are not Medicaid billable or reimbursable.
7. Partial hospitalization shall be:
   a. Provided for at least four (4) hours per day; and
   b. Focused on one (1) primary presenting problem.
8. A partial hospitalization program operated by a behavioral health services organization shall:
   a. Include the following personnel for the purpose of providing medical care:
      (i) An advanced practice registered nurse, a physician assistant, or a physician available on site; and
      (ii) A board-certified or board-eligible psychiatrist available for consultation; and
   b. Have the capacity to:
      (i) Provide services utilizing a recognized intervention protocol based on nationally accepted treatment principles;
      (ii) Employ required practitioners and coordinate service provision among rendering practitioners; and
      (iii) Provide the full range of services included in the scope of partial hospitalization established in this paragraph.
9. Partial hospitalization services shall be provided by:
   a. An approved behavioral health practitioner; or
   b. An approved behavioral health practitioner under supervision.

Section 4. Additional Limits and Non-covered Services or Activities. (1)(a) Except as established in paragraph (b) of this subsection, unless a diagnosis is made and documented in the recipient’s medical record within three (3) visits, the service shall not be covered.
   (b) The requirement established in paragraph (a) of this subsection shall not apply to:
      1. Mobile crisis services;
      2. Crisis intervention;
      3. A screening; or
   (2) For a recipient who is receiving residential services for substance use disorders, the following shall not be billed or reimbursed for the same date of service for the recipient:
      (a) A screening;
      (b) An assessment;
      (c) Service planning;
      (d) A psychiatric service;
      (e) Individual outpatient therapy;
      (f) Group outpatient therapy;
      (g) Family outpatient therapy; or
      (h) Peer support services.
   (3) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same date of service for the recipient:
      (a) An assessment;
      (b) Case management;
(c) Individual outpatient therapy;  
(d) Group outpatient therapy;  
(e) Peer support services; or  
(f) Mobile crisis services.

(3) The department shall not reimburse for both a screening provided pursuant to this administrative regulation and a screening, brief intervention and referral to treatment (SBIRT) provided pursuant to 907 KAR 15:022 to a recipient on the same date of service.

(4) The following services or activities shall not be covered under this administrative regulation:

(a) A service provided to:  
1. A resident of:  
   a. A nursing facility; or  
   b. An intermediate care facility for individuals with an intellectual disability;  
2. An inmate of a federal, local, or state:  
   a. Jail;  
   b. Detention center; or  
   c. Prison; or  
3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;  
(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the behavioral health services organization;  
(c) A consultation or educational service provided to a recipient or to others;  
(d) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face" established in 907 KAR 15:005, Section 1(21). Contact prohibited under subparagraph 1. of this paragraph may be permissible if it is conducted in the course of a telehealth service permitted pursuant to 907 KAR 3:170 or this administrative regulation;  
(e) Travel time;  
(f) A field trip;  
(g) A recreational activity;  
(h) A social activity; or  
(i) A physical exercise activity group.

(5) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as established in Section 3(6)(3)(1) of this administrative regulation.

(b) A third party contract shall not be covered under this administrative regulation.

(6) A billing supervisor arrangement between a billing supervisor and an approved behavioral health practitioner under supervision shall not violate the supervision rules or policies of the respective professional licensure boards governing the billing supervisor and the approved behavioral health practitioner under supervision.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independent behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a behavioral health services organization.
Section 6. Records Maintenance, Documentation, Protection, and Security. (1) A behavioral health services organization shall maintain a current health record for each recipient.

(2)[(a)] A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.[(b)] The individual who provided the service shall date and sign the health record on the date that the individual provided the service except as established in subsection (5)(a) of this section.

(3) A health record shall:
   (a) Include:
      1. An identification and intake record including:
         a. Name;
         b. Social Security number;
         c. Date of intake;
         d. Home (legal) address;
         e. Health insurance or Medicaid information;
         f. Referral source and address of referral source;
         g. Primary care physician and address;
         h. The reason the individual is seeking help including the presenting problem and diagnosis;
         i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:
            (i) Where the individual is receiving treatment for the physical health diagnosis; and
            (ii) The physical health provider; and
         j. The name of the informant and any other information deemed necessary by the behavioral health services organization to comply with the requirements of:
            (i) This administrative regulation;
            (ii) The behavioral health services organization’s licensure board;
            (iii) State law; or
            (iv) Federal law;
      2. Documentation of the:
         a. Screening;
         b. Assessment if an assessment was performed; and
         c. Disposition if a disposition was performed;
      3. A complete history including mental status and previous treatment;
      4. An identification sheet;
      5. A consent for treatment sheet that is accurately signed and dated; and
      6. The individual’s stated purpose for seeking services; and
   (b) Be:
      1. Maintained in an organized central file;
      2. Furnished to the:
         a. Cabinet for Health and Family Services upon request; or
         b. Managed care organization in which the recipient is enrolled upon request if the recipient is enrolled with a managed care organization;
      3. Made available for inspection and copying by:
         a. Cabinet for Health and Family Services’ personnel; or
         b. Personnel of the managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;
      4. Readily accessible; and
      5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient if the recipient received services beyond a screening.
(4) Documentation of a screening shall include:
   (a) Information relative to the individual’s stated request for services; and
   (b) Other stated personal or health concerns if other concerns are stated.
(5)(a) A behavioral health services organization’s [service note] regarding a recipient shall:
   1. Be made within forty-eight (48) hours of each service visit; [and]
   2. Indicate if the service was provided face-to-face or via telehealth; and
   3. Describe the:
      a. Recipient’s symptoms or behavior, reaction to treatment, and attitude;
      b. Therapist’s intervention;
      c. Changes in the plan of care if changes are made; and
      d. Need for continued treatment if continued treatment is needed.
   (b)1. Any edit to notes shall:
      a. Clearly display the changes; and
      b. Be initialed and dated by the person who edited the notes.
   2. Notes shall not be erased or illegibly marked out.
   (c)1. Notes recorded by an approved behavioral health practitioner under supervision shall be co-signed and dated by the supervising professional within thirty (30) days.
      2. If services are provided by an approved behavioral health practitioner under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the approved behavioral health practitioner under supervision concerning the:
         a. Case; and
         b. Supervising professional’s evaluation of the services being provided to the recipient.
(6) Immediately following a screening of a recipient, the practitioner shall perform a disposition related to:
   (a) A provisional diagnosis;
   (b) A referral for further consultation and disposition, if applicable; or
   (c)1. If applicable, termination of services and referral to an outside source for further services; or
      2. If applicable, termination of services without a referral to further services.
(7) Any change to a recipient’s plan of care shall be documented, signed, and dated by the rendering practitioner and by the recipient or recipient’s representative.
(8)(a) Notes regarding services to a recipient shall:
   1. Be organized in chronological order;
   2. Be dated;
   3. Be titled to indicate the service rendered;
   4. State a starting and ending time for the service; and
   5. Be recorded and signed by the rendering practitioner and include the professional title (for example, licensed clinical social worker) of the provider.
   (b) Initials, typed signatures, or stamped signatures shall not be accepted.
   (c) Telephone contacts, family collateral contacts not covered under this administrative regulation, or other non-reimbursable contacts shall:
      1. Be recorded in the notes; and
      2. Not be reimbursable.
(9)(a) A termination summary shall:
   1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and
   2. Contain a summary of the significant findings and events during the course of treatment
including the:
   a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual’s plan of care;
   b. Final diagnosis of clinical impression; and
   c. Individual’s condition upon termination and disposition.

(b) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(10) If an individual’s case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(11)(a) Except as established in paragraph (b) of this subsection, if a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring behavioral health services organization shall, within ten (10) business days of the transfer or referral, transfer the recipient’s records in a manner that complies with the records’ use and disclosure requirements as established in or required by:
   1.a. The Health Insurance Portability and Accountability Act;
   b. 42 U.S.C. 1320d-2 to 1320d-8; and
   c. 45 C.F.R. Parts 160 and 164; or
   2.a. 42 U.S.C. 290 ee-3; and
   b. 42 C.F.R Part 2.

(b) If a recipient is transferred or referred to a residential crisis stabilization unit, a psychiatric hospital, a psychiatric distinct part unit in an acute care hospital, or an acute care hospital for care or treatment, the transferring behavioral health services organization shall, within forty-eight (48) hours of the transfer or referral, transfer the recipient’s records in a manner that complies with the records’ use and disclosure requirements as established in or required by:
   1.a. The Health Insurance Portability and Accountability Act;
   b. 42 U.S.C. 1320d-2 to 1320d-8; and
   c. 45 C.F.R. Parts 160 and 164; or
   2.a. 42 U.S.C. 290 ee-3; and
   b. 42 C.F.R Part 2.

(12)(a) If a behavioral health services organization’s Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of an owner or deaths of owners, the health records of the behavioral health services organization shall:
   1. Remain the property of the behavioral health services organization; and
   2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A behavioral health services organization shall have a written plan addressing how to maintain health records in the event of death of an owner or deaths of owners.

(13)(a) Except as established in paragraph (b) or (c) of this subsection, a behavioral health services organization shall maintain a case record regarding a recipient for at least six (6) years from the date of the service or until any audit dispute or issue is resolved beyond six (6) years.

(b) After a recipient’s death or discharge from services, a provider shall maintain the recipient’s record for the longest of the following periods:
   1. Six (6) years unless the recipient is a minor; or
   2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

(c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, the behavioral health services organization shall:

   1. Maintain the record for the periods required by the Secretary of the United States Department of Health and Human Services; and
   2. Maintain the record for the longest of the periods referenced in paragraph (b) of this subsection; and
   3. Maintain the record for the longest of the periods referenced in paragraph (a) of this subsection.

   (d) If a recipient’s condition is such that the Secretary of the United States Department of Health and Human Services requires a longer document retention period, a behavioral health services organization shall:

   1. Maintain the record for the periods required by the Secretary of the United States Department of Health and Human Services; and
   2. Maintain the record for the longest of the periods referenced in paragraph (b) of this subsection; and
   3. Maintain the record for the longest of the periods referenced in paragraph (a) of this subsection.

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tion[section], pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(14)(a) A behavioral health services organization shall comply with 45 C.F.R. Part 164.
(b) All information contained in a health record shall:
1. Be treated as confidential;
2. Not be disclosed to an unauthorized individual; and
3. Be disclosed to an authorized representative of:
   a. The department; or
   b. Federal government.
(c)(1) Upon request, a behavioral health services organization shall provide to an authorized representative of the department or federal government information requested to substantiate:
   a. Staff notes detailing a service that was rendered;
   b. The professional who rendered a service; and
   c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department.
2. Failure to provide information required by subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 7. Medicaid Program Participation Compliance. (1) A behavioral health services organization shall comply with:
(a) 907 KAR 1:671;
(b) 907 KAR 1:672; and
(c) All applicable state and federal laws.
(2)(a) If a behavioral health services organization receives any duplicate payment or overpayment from the department, regardless of reason, the behavioral health services organization shall return the payment to the department.
(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection[section] may be:
1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.
(3)(a) When the department makes payment for a covered service and the behavioral health services organization accepts the payment:
1. The payment shall be considered payment in full;
2. A bill for the same service shall not be given to the recipient; and
3. Payment from the recipient for the same service shall not be accepted by the behavioral health services organization.
(b)(1) A behavioral health services organization may bill a recipient for a service that is not covered by the Kentucky Medicaid Program if the:
   a. Recipient requests the service; and
   b. Behavioral health services organization makes the recipient aware in advance of providing the service that the:
      (i) Recipient is liable for the payment; and
      (ii) Department is not covering the service.
2. If a recipient makes payment for a service in accordance with subparagraph 1 of this paragraph, the:
   a. Behavioral health services organization shall not bill the department for the service; and
   b. Department shall not:
      (i) Be liable for any part of the payment associated with the service; and
      (ii) Make any payment to the behavioral health services organization regarding the service.
(4)(a) A behavioral health services organization shall attest by the behavioral health services organization’s staff’s or representative’s signature that any claim associated with a service is valid and submitted in good faith.

(b) Any claim and substantiating record associated with a service shall be subject to audit by the:
1. Department or its designee;
2. Cabinet for Health and Family Services, Office of Inspector General, or its designee;
3. Kentucky Office of Attorney General or its designee;
4. Kentucky Office of the Auditor for Public Accounts or its designee; or
5. United States General Accounting Office or its designee.

(c) If a behavioral health services organization receives a request from the department to provide a claim, related information, related documentation, or record for auditing purposes, the behavioral health services organization shall provide the requested information to the department within the timeframe requested by the department.

(d) 1. All services provided shall be subject to review for recipient or provider abuse.
2. Willful abuse by a behavioral health services organization shall result in the suspension or termination of the behavioral health services organization from Medicaid Program participation.

Section 8. Third Party Liability. A behavioral health services organization shall comply with KRS 205.622.

Section 9. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A behavioral health services organization that chooses to use electronic signatures shall:
(a) Develop and implement a written security policy that shall:
1. Be adhered to by each of the behavioral health services organization’s employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;
(b) Develop a consent form that shall:
1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature’s authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and
(c) Provide the department, immediately upon request, with:
1. A copy of the behavioral health services organization’s electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 10. Auditing Authority. The department shall have the authority to audit any:
(1) Claim;
(2) Medical record; or
(3) Documentation associated with any claim or medical record.

Section 11. Federal Approval and Federal Financial Participation. The department’s coverage of services pursuant to this administrative regulation shall be contingent upon:
(1) Receipt of federal financial participation for the coverage; and
(2) Centers for Medicare and Medicaid Services’ approval for the coverage.

Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.
(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

Section 13. Delayed Implementation Date. The provisions of this administrative regulation shall be implemented beginning July 1, 2019.

CAROL H. STECKEL, Commissioner
ADAM M. MEIER, Secretary
APPROVED BY AGENCY: June 17, 2019
FILED WITH LRC: June 28, 2019 at 4 p.m.
CONTACT PERSON: Chase Coffey, Executive Administrative Assistant, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; phone: 502-564-6746; fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Chase Coffey

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by Tier I behavioral health services organizations (BHSO I). A BHSO I is an entity that provides treatment for mental health and is licensed and regulated by the Office of Inspector General in accordance with 902 KAR 20:430. The array of services includes a screening; an assessment; psychological testing; crisis intervention; mobile crisis services; day treatment; peer support; intensive outpatient program services; individual outpatient therapy; group outpatient therapy; family outpatient therapy; collateral outpatient therapy; service planning; partial hospitalization; assertive community treatment; comprehensive community support services; and therapeutic rehabilitation program services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with KRS 205.6311, which mandates that Kentucky’s Medicaid Program "expand the behavioral health network to allow providers to provide services within their licensure category."
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by expanding "the behavioral health network to allow providers to provide services within their licensure category."
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by expanding "the behavioral health network to allow providers to provide services within their licensure category."
(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendments include establishing the first tier, of what will be a 3-tiered division of BHSO services. The new tiers will divide BHSO services provided for non-substance use disorder (SUD) treatment services, outpatient SUD treatment services, and residential SUD treatment services. Each tier will require different licensure. The amendments to the administrative regulation require that a BHSO I only provide mental health treatment, and not SUD treatment. Accreditation is now required within one year of initial enrollment. In addition, certain types of providers and support staff are not allowed to practice within a BHSO I. The amendments also better refer to the defined terms of an "approved behavioral health practitioner" or an "approved behavioral health practitioner under supervision", and these terms now include certain additional practitioners. The amendments also require physicians and advance practice registered nurses providing behavioral health services within a BHSO I to have a psychiatric specialty. Physician assistants are now required to have a contractual relationship with a supervising physician with a psychiatric specialty in order to provide behavioral health services within a BHSO I. The amendments further clarify that face-to-face contact between the provider and recipient is not required for family therapy which involves informing family members (in the absence of the recipient) regarding the recipient's psychological testing and service planning. The amendments further clarify that the three (3) hour per day limit regarding individual outpatient therapy, group outpatient therapy, and family outpatient therapy applies to each service or any combination of the therapies in aggregate. The amendments also make organizational changes by deleting language that listed the service and appropriate provider, this information has now been consolidated and included with the subsection that addresses covered services.

(b) The necessity of the amendment to this administrative regulation: The amendments are necessary to increase treatment licensure and quality standards as a part of a cabinet-wide process mandated by HB 124 of the 2018 Regular Session. Additional clarifications relating to face-to-face contact for family therapy, psychological testing, and service planning were necessary to reflect that these services may be conducted without the recipient present. Clarifying that the three (3) hour limit regarding individual outpatient therapy, group outpatient therapy, and family outpatient therapy is an aggregate as well as individual service limit is necessary for clarity.

(c) How the amendment conforms to the content of the authorizing statutes: The amendments conform to the content of the authorizing statutes by enhancing and ensuring that licensure standards and SUD treatment meet a standard established by HB 124 of the 2018 Regular Session, in addition, the amendments help meet recipient demand as well as conforms to the content of KRS 205.6311(2).

(d) How the amendment will assist in the effective administration of the statutes: The amendments will assist in the effective administration of the authorizing statutes by implementing part of a tiering process of BHSOs according to the licensure and type of services provided, and by enabling additional practitioners throughout the new tiers to provide services to help meet recipient demand. In addition, the amendments will assist with conforming to the content of KRS 205.6311(2).

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are currently 134 entities licensed as behavioral health services organizations that will be affected by this administrative regulation. Medicaid recipients in need of substance use treatment, mental health treatment, or treatment for a co-occurring disorder will also be affected by the amendment. There are currently 1.4 million individuals enrolled in the Medicaid program.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an
amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Providers that plan to provide non-SUD treatment will need to only attain or retain BHSO licensure. In addition, BHSOs will need to ensure that the appropriate services are provided by the appropriate provider.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Entities that only provide non-SUD treatment services will only need to attain or retain BHSO licensure.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients in need of mental health treatment that does not include SUD treatment will have access to a broad range of mental health treatment. Facilities may provide many services with no need for dual licensure due to these changes. Currently there are 1.4 million Kentuckians receiving Medicaid services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS does not anticipate additional costs as a result of the amendments to this administrative regulation.

(b) On a continuing basis: DMS does not anticipate additional costs as a result of the amendments to this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Substance use disorder services are federally mandated for Medicaid programs. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization
which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services.” Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization’s provider network. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid.) Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.

   (c) How much will it cost to administer this program for the first year? DMS does not expect any additional costs in administering these amendments during the first year.

   (d) How much will it cost to administer this program for subsequent years? DMS does not expect any additional costs in administering these amendments during subsequent years.

   Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

   Revenues (+/-): 
   Expenditures (+/-): 
   Other Explanation: